Appeals: Eligibility & Health Plan Decisions in the Health Insurance Marketplace

There are 2 kinds of appeals you can make once you've applied and enrolled in coverage through the Health Insurance Marketplace:

- **Eligibility decisions:** After you've applied for coverage in the Marketplace, you'll get an eligibility notice that explains what you qualify for. If you don't agree with that notice, you may be able to appeal.
- **Health plan decisions:** You may be able to appeal health plan decisions your Marketplace plan makes about covered services. For example, if your health insurer refuses to pay a claim or ends your coverage, you have the right to appeal the decision and have it reviewed by a third party.

Tip: No matter what kind of appeal you make, keep copies of all information related to it. This includes paperwork, notes from phone calls, and any other documentation that's sent to you, or that you send to the Marketplace or the insurance company.

Appealing eligibility decisions

You can appeal:

- Whether you're eligible to buy a Marketplace plan.
- Whether you can enroll in a Marketplace plan outside the regular Open Enrollment Period.
- Whether you're eligible for lower monthly premiums based on your income.
- The amount of savings you're eligible for when you use services through your Qualified Health Plan.
- Whether you're eligible for Medicaid or the Children's Health Insurance Program (CHIP), but only if your state allows us to consider these appeals.
- Whether you're exempt from having to pay a fee because you don't have health coverage. (**Note:** You must request an exemption from the requirement to have health coverage by filing an exemption request with the Marketplace or the IRS (depending on the type of exemption). If the request is denied, you can appeal the denial. For more information about exemptions, visit **HealthCare.gov/fees-exemptions/exemptions-from-the-fee/**)

You can learn more about all of the eligibility decisions that the Marketplace makes at **HealthCare.gov.**

How do I file a Marketplace eligibility appeal?

You can file a Marketplace eligibility appeal by:

- Visiting **HealthCare.gov/marketplace-appeals** and downloading an appeal request form. Complete it, then mail to the address shown on the form.
- Writing a letter explaining the reason for your appeal. Include your name, address, and the application ID number from your eligibility determination notice. Mail the letter to:

  Health Insurance Marketplace
  465 Industrial Blvd.
  London, KY 40750-0061

For information on how to get help with the appeals process see the section titled "Getting help with my appeal" on pages 4-5.

What happens after I ask for a Marketplace eligibility appeal?

Once you submit your eligibility appeal, the Marketplace Appeals Center will review your request. You'll get a letter in the mail letting you know that they received your appeal. The Marketplace Appeals Center will contact you to discuss your appeal and will work with you to resolve your appeal informally. If you have questions about your eligibility appeal, call the Marketplace Appeals Center at 1-855-231-1751. TTY users should call 1-855-739-2231.

If you're not satisfied with the outcome of the informal resolution of your eligibility appeal, you have the right to a hearing. A hearing is a more formal way for you to present your case and get a decision on your appeal. If you want a hearing, a federal hearing officer will conduct it, usually by phone. You'll get a letter in the mail 15 days before your hearing with the date, time, and instructions on how to call into the hearing.

If you don't show up for your hearing, your appeal could be dismissed. If your appeal is dismissed, it's the same as if you had never filed an appeal, and your last Marketplace eligibility determination will remain in effect.

After your eligibility appeal is determined, you'll get a letter in the mail explaining the decision.

What if my health situation is urgent?

You can ask us for an expedited (fast) appeal if you have an urgent health situation. This means that the time needed for the standard appeal process would jeopardize your life, or your ability to attain, maintain, or regain maximum function. You can tell us about your urgent health need for a faster eligibility appeal in your letter or by completing the "Eligibility Appeal Request" form and including an explanation of why you need a faster eligibility appeal.

Your request to expedite your appeal should specifically explain how a standard appeal would jeopardize your life or your ability to attain, maintain, or regain maximum function. An explanation from your doctor or other health providers in writing attached to your eligibility appeal request will help us decide if we can expedite your appeal (move it faster). For information on how to get help with the appeals process, see the section titled "Getting help with my appeal" on pages 4-5.

If we expedite your appeal, we'll call you to process your appeal quickly. If your situation doesn't qualify for the appeal to be expedited, we'll send you a notice and your eligibility appeal will be processed through the standard eligibility appeals process.

Your request to expedite your appeal will be processed as quickly as possible. If your appeal is expedited, a final decision will be made as quickly as possible.

What if I want to cancel my appeal?

If you want to cancel your eligibility appeal, call the Marketplace Appeals Center at 1-855-231-1751. TTY users should call 1-855-739-2231. Tell them you want to cancel your appeal. You can also write a letter to cancel your appeal. Send your letter to:

Marketplace Appeals Center
PO Box 311
Pittston, PA 18640

If you cancel your appeal, it's the same as if you had never filed the appeal, and your last Marketplace eligibility determination will remain in effect.

Appealing a health plan decision

If your health plan ends your coverage or refuses to pay a claim that you filed, you have the right to appeal the decision and have it reviewed by a third party.

Your plan must notify you in writing and explain why you were denied within a set amount of time (based on the type of claim you filed). They also have to let you know how you can appeal their decision.

Steps of the appeals process:

1. After your health insurer denies your claim or ends your coverage, you can begin the appeals process. Any instructions specific to your health insurer will be listed on the information they sent to you when they denied your claim or ended your coverage.
2. An **internal appeal** is the first action you can take, and you must file it within 180 days (6 months) of receiving notice that your claim was denied or your coverage was ended. To file an internal appeal you must:
   - Complete all forms required by your health insurer, or write to your insurer with your name, claim number, and the health insurance ID number required by your plan.
   - Submit any additional information that you want the insurer to consider, like a letter from your doctor.
3. At the end of the internal appeals process, your insurance company must provide you with a written decision. In most cases, if your insurance company still denies you service, payment for a service, or ends your coverage, you can ask for an external review. The insurance company's final determination must tell you how to ask for an external review.

4. An external review is the final step in the appeals process.

   - Typically, you must file a written request for an external review within 60 days of the date your insurer sent you a final decision. The notice sent to you by your health insurance issuer or health plan should tell you the timeframe in which you must make your request.
   - You may appoint a representative (like your doctor or another medical professional) who knows about your medical condition to file an **external review** on your behalf.
   - The information on your "Explanation of Benefits (EOB)" or on the final denial of the internal appeal by your health plan will give you the contact information for the organization that will handle your external review.
   - The external reviewer will issue a final decision. An external review either upholds your insurer's decision or decides in your favor. **Your insurer is required by law to accept the external reviewer's decision.** Standard external reviews are decided as soon as possible - no later than 60 days after the request was received.

Insurance companies in all states must participate in an external review process that meets the consumer protection standards of the health care law. Your state may have an external review process that meets or goes beyond these standards. If so, insurance companies in your state will follow your state's external review processes.

If your state doesn't have an external review process that meets the minimum consumer protection standards, the plans and insurers within the state must choose between 1 of 2 options for external review. The external review can be conducted by an independent review organization or by the federal government's Department of Health and Human Services (HHS).

Note: You can file your internal appeal and external review at the same time, or file an expedited appeal, if the timeline for the standard appeal process would seriously jeopardize your life or your ability to regain maximum function. A final decision about your appeal must come as quickly as your medical condition requires.

Getting help with my appeal

Whether you're appealing an eligibility decision or a health plan decision, you don't have to do it alone. There are many resources available to help you with your appeal.

- Your state's Consumer Assistance Program (CAP) or Department of Insurance may be able to help you, along with other local organizations. Visit LocalHelp.HealthCare.gov to find help in your area.
- If you appealed your Marketplace eligibility results, you can call the Marketplace Appeals Center at 1-855-231-1755. TTY users should call 1-855-739-2231.
- You have the right to get help and information about appeals and other Marketplace issues in your preferred language at no cost. The Marketplace Call Center can help you get an interpreter so you can present your case in your preferred language. Call 1-800-318-2596. TTY users should call 1-855-739-2231. During your Marketplace eligibility appeal, the Marketplace Appeals Center can also help you find an interpreter.

You can also appoint an authorized representative to help you file your appeal. Your authorized representative can file an appeal on your behalf (with your consent) or just help you with your appeal. Your representative can be a family member, friend, advocate, attorney, or someone else who will act for you.

If you want to appoint a representative, you can do so 1 of 2 ways:

1. Complete an "Appointment of Representative" form.
    - Visit **HealthCare.gov/marketplace-appeals**
    - Download an appeal request form.
    - Complete and submit **"Appendix C: Assistance completing this application."**

2. Submit a written request with your appeal. Be sure to include:
    - Your name, address, and phone number.
    - Your (case/record/request/file) number.
    - A statement appointing someone as your representative.
    - The name, address, and phone number of your representative.
    - The professional status of your representative or their relationship to you.